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STATE SENATOR

Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue

April 22, 2009

Good Afternoon Chairman Erpenbach and Committee members.

Thank you for the opportunity to testify on my Five Point Health Insurance Reform Plan. Over the past several months, Commissioner Dilweg and I collaborated on reforms to our health insurance regulations to bring certainty and consumer protection to those who purchase health insurance, especially in the individual market.

Our work is before you in Senate Bills 70, 71, 72. In addition, Senate Bills 73 and 74 are simple modifications to the state's Health Insurance Risk Sharing Pool (HIRSP).

In the current economy people are losing their jobs, which means they are also losing their health coverage. More people are increasingly relying on the individual insurance market for coverage. People want to know when they buy insurance they are really getting the coverage they expected.

Yet Wisconsin falls behind many other states in setting rules to protect consumers.

A recent report released by Families USA gave Wisconsin a failing grade on state consumer protections in the individual health insurance market. The findings of the report cited Wisconsin's current 2-year time limit on pre-existing condition exclusions as too long. A majority of states limit pre-existing conditions to twelve months or less. Wisconsin can too.

Additionally, Wisconsin doesn't protect consumers from having claims denied because the insurance companies are digging back years into the policyholder's medical history and alleging the individual should have known about a pre-existing condition. Twenty five other states limit this practice.

The proposals before you today would improve protections for consumers in several important ways:

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Expanding Coverage

Health Insurance Coverage for Adult Children

- Require group and individual health insurance policies to cover unmarried adult children through 26 years of age under their parents' policies. The cost of coverage for adult children 19 through 26 years of age shall be included in the premium on the same basis as other dependent coverage. We know young adults are the least likely people to have coverage; approximately thirty percent of those age 19 to 29 are uninsured; thirty states require some coverage of adult children; ten states do not define dependents or allow this coverage even if they are not in school or financially dependent.

- In addition to adult child coverage through the age of 26, also require group and individual health insurance policies to cover any child, regardless of age, under their parent's policy whose education is interrupted by services in the National Guard or Reserves.

Modifications to HIRSP Eligibility and Flexibility in Maximum Lifetime Limits

- Currently people seeking coverage under the state's Health Insurance Risk Sharing Pool (HIRSP) must demonstrate that they have, in the past 9 months prior to application, received a notice of rejection from 2 or more insurers.

- This bill revises current law to require only one rejection notice for eligibility into HIRSP.

- Major medical expense coverage offered under HIRSP is currently subject to a lifetime limit of $1,000,000. This bill allows the HIRSP Authority to increase the lifetime limit.

- Both of these modifications have the approval of the HIRSP Board.

Increasing Portability and Making It Easier For People To Change Insurance

Choices in Coverage

- The proposal allows consumers, at the time of their policy renewal to change coverage to a comparable product currently offered by their insurer or modify their existing coverage. These choices may include additional coverage, more limited benefits or higher deductibles. The consumer shall not be subject to any additional underwriting or any new preexisting conditions exclusion that did not apply to his or her original coverage.

Creditable Coverage

- The maximum pre-existing condition exclusion period for **group health insurance policies** is 12 months. Currently, if a person loses health insurance coverage but picks up coverage within **63** days, they can apply creditable coverage to the 12 month exclusion period.

- This bill allows individuals who lose health insurance coverage and pick up new group coverage within **90** days, to apply creditable coverage to the maximum pre-existing condition exclusion period on the new group policy.

Setting Limits on How "Pre-Existing Conditions" Can Be Used to Limit Coverage and Deny Claims

Limit Pre-existing Condition Exclusion to One Year

- The Kaiser Family Foundation explains the "maximum pre-existing condition exclusion period" as a limit on post-claims underwriting. Any claim filed during the exclusion period can be investigated as possibly pre-existing and, if found to be so, can be denied and coverage for all further care for that condition can be excluded during the exclusion period.

- The current pre-existing condition exclusion period for individual health insurance coverage in Wisconsin is 2 years. This bill limits the pre-existing condition exclusion period for individual health insurance coverage to 1 year. (at least 25 states are at one year or less).

Limit Pre-existing Condition Look Back Period

- The Kaiser Family Foundation explains the, "maximum look back period" as limiting the period of history preceding purchase of a policy that can be investigated for evidence of a preexisting condition.

- Current Wisconsin law does not place a limit on the maximum look back period. This bill would limit the "maximum look back period" for pre-existing conditions to 1 year. (26 states do this).

Require "Objective Standard" in Determining Whether a Pre-Existing Condition was Present Prior to Application for Coverage

- This proposal would apply the "objective standard" rather than the "prudent person standard" in determining pre-existing conditions under individual health insurance policies.

- The 'objective standard' allows only those conditions for which someone actually received medical advice, diagnosis, care or treatment prior to enrollment to be counted as pre-existing.

- Current law references the "prudent person standard" in determining whether a pre-existing condition was present prior to the individual's date of enrollment for coverage by an individual health plan.

- The 'prudent person" standard includes conditions that were never diagnosed, but which exhibited symptoms for which an ordinary prudent person would have sought medical advice, care or treatment. 18 states follow the objective standard for defining pre-existing conditions.

Bringing Fairness to Appeals

Consumers Can Choose an External Review for Rescission or Exclusion

- Current law allows for independent review of adverse and experimental treatment determinations. There is no provision for review for dropped coverage or exclusion of pre-existing conditions.

- This proposal allows for an independent review of rescissions and pre-existing exclusion denial determinations at no cost to the consumer.

Evaluating Results

Standard Application Form

- This proposal gives the Commissioner of Insurance the authority to establish uniform insurance application with standard underwriting questions.

Evaluation and Annual Reporting

- This proposal also requires every insurer to annually report the total number of individual health insurance policies issued and the total number of policy cancellations or rescissions that were initiated or completed.

I urge the committee to support these health insurance proposals. While we continue to concentrate on reaching agreement on big picture health reform, we can take the small and immediately achievable steps to bring increased coverage, certainty and fairness to health insurance.

Thank you for your consideration.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Testimony of Eileen Mallow, Assistant Deputy Commissioner
To the Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief and Revenue
Senate Bill 72
April 22, 2009

Chairman Erpenbach and Members of the Committee:

Thank you for the opportunity to testify in support of Senate Bill 72, relating to portability under group health benefit plans and independent review of insurance policy rescissions and preexisting condition exclusion denials under group and individual benefit plans.

In light of current economic pressures and the challenges some face in accessing health care coverage, business practices in the individual health insurance market with respect to preexisting condition exclusions and rescissions is increasingly gaining more attention. For example, United States Representative Henry Waxman, Chairman of the House Committee on Oversight and Government Reform, held a hearing in July 2008 focused on the practice of rescission in the individual health insurance market. In October 2008, he reached out to states requesting information on state regulatory oversight of rescissions in an effort to further the Committee's understanding of market practices.

The Office of the Commissioner of Insurance (OCI) received 343 complaints relating to preexisting conditions and recessions from January 2006 through March 2009. As a result of OCI's experience with such complaints, as well as those in several other state insurance departments, the National Association of Insurance Commissioners continues work on a national survey regarding individual health insurer business practices with respect to recession and exclusion decisions. The goal is to better understand current practice and its impact on consumers.

The requirement in SB 72 that insurers issuing individual health benefit plans report to the Commissioner annually the number of benefit plans issued and the number of plans where the insurer initiated or completed a cancellation or rescission, will help in understanding market practices.

In an effort to empower consumers impacted by preexisting condition determinations and rescissions, SB 72 expands independent review options under current law to include a preexisting condition exclusion denial determination and the rescission of a policy. Therefore, individuals who are denied coverage for these reasons can pursue third party review by an independent review organization (IRO), after an internal grievance with the insurance company is complete. Independent review organizations are certified by the Commissioner and must demonstrate that they are unbiased.

IRO's must be recertified on a biennial basis to continue to provide services. There are currently six certified IRO's. SB 72 specifically requires that at least one independent review organization is certified to effectively provide reviews relating to preexisting condition exclusion denial determinations and rescissions.

Lastly, SB 72 improves portability in the individual health care market. Currently, when determining how long preexisting condition exclusion periods may be imposed under new health insurance coverage, a person must be given credit for the time during which he or she previously had health insurance coverage. SB 72 allows past coverage to be applied if new coverage is obtained within 90 days. Current law allows for a 63 day window. The additional month provided in SB 72 allows individuals more time to assess their situation and shop for new coverage.

Thank you again for the opportunity to testify in support of SB 72. I am happy to answer any questions.